

STATE OF INDIANA: TRADITIONAL PLAN II Blue AccessSM (PPO) Summary of Benefits for 2007

COVERED BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESPONSIBILITY)
Deductible (Single/Family) <i>(Applies only to percent (%) copayments)</i> <i>Deductibles are co-mingled network and non-network</i>	\$500 single Network/Non-network (\$0 single Network/Non-Network with Tobacco Incentive) \$500 family Network/Non-network (\$0 family Network/Non-Network with Tobacco Incentive) Deductible applies to Prescription Drugs
Out of Pocket Maximum (Single/Family) Out of pockets are co-mingled network and non-network Rx copay(s) do not accrue to out of pocket	\$2,000 per enrollee \$4,000 per family The out of pocket maximum limit accrues on a calendar year basis. After the out of pocket limit has been met, benefits are paid at 100% of covered charges for the remainder of that calendar year.
Professional Office Services <ul style="list-style-type: none"> Including allergy <ul style="list-style-type: none"> testing and treatment serum and injections 	\$20 Network/ 40% Non-network Per Visit
Preventative Care Services	\$20 Office Visit Copay Network/40% Non-network Services include: immunizations for eligible dependents, annual physicals for employees and their eligible covered dependents, flu shots, annual pap smears and diagnostic services performed with the annual physical. This benefit does not include inpatient services or surgical procedures.
Maternity Services	\$500 Network/ 40% Non-Network
Inpatient Facility Services	\$500 Network/40% Non-Network
Outpatient Facility Services	\$250 Network/ 40% Non-network
Professional Inpatient/Outpatient Services	Covered in full Network/40% Non-Network Subject to deductible
Emergency and Urgent Care: <ul style="list-style-type: none"> Emergency Care in ER Room Urgent Care Facility 	\$75 Network or Non-Network \$35 Network or Non-Network
Ambulance	\$50 Copay Network or Non-Network
Radiation/Inhalation Therapy	\$20 Office Visit Copay Network/ 40% Non-network
Medical Supplies, Equipment and Appliances	20% Network/40% Non-network Subject to deductible
Outpatient Therapy Services (Combined Network and Non-network limits apply) Limits apply to: <ul style="list-style-type: none"> Physical therapy: 25 visits Occupational therapy: 25 visits Manipulation therapy: 12 visits Speech therapy: 25 visits 	\$20 Office Visit Copay Network/ 40% Non-network
Mammogram	\$20 Office Visit Copay Network/ 40% Non-network Includes 1 per person, per calendar year. Additional mammography services and ultrasounds are covered as determined medically necessary by your physician.
Routine Prostate Antigen Tests (PSA)	\$20 Office Visit Copay Network/ 40% Non-network Includes 1 per person, per calendar year
Colorectal Cancer Exam/Laboratory Testing	\$20 Office Visit Copay Network/ 40% Non-network
Diabetes Self Management Training	\$20 Office Visit Copay Network/40% Non-network

Diagnostic Services i.e. lab, x-ray, MRI	Covered in full Network/40% Non-network Subject to deductible																													
Temporomandibular Joint (TMJ) Services	Outpatient Facility \$250 Copay Network / 40% Non-network Provider Individual: \$20 Office Visit Copay/ Network/40% Non-network TMJ Surgery: Covered in full Network/40% Non-network Subject to deductible TMJ Services: \$2,500 lifetime maximum for all services (network/non-network)																													
Hospice	20% Network/20% Non-network Subject to deductible																													
Home Health Care No RN/LPN unless billed through a Home Health Care Agency	\$20 Copay per day Network/ 40% Non-network Private Duty Nursing limited to \$5,000 plan maximum per enrollee																													
Home IV Therapy	\$20 Copay per day Network/ 40% Non-network																													
Employee Assistance Program	Provides consultation and referral services for personal concerns for employees and their household members.																													
Managed Mental Health including Substance Abuse Covered Same As Any Other Condition	Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed. \$500 In Patient Copay Network/ 40% Non-network \$20 Office Visit Copay Network/ 40% Non-network *THESE SERVICES MUST BE CERTIFIED BY CONTRACTOR TO RECEIVE BENEFITS.																													
Lifetime Maximum Includes Human Organ and Tissue Transplants (HOTT)	\$2 million Network and Non-network combined																													
Human Organ and Tissue Transplants (HOTT) Specialty Network	\$2,000 Network / 40% Non- network See contract for other maximums and exclusions																													
Prescription Drug Options: Network Tier structure equals 1/2/3 (and 4, if applicable) Including Birth Control Network Retail Pharmacies: 100% of allowable cost after copayment up to a maximum of 34-days supply of medication or 100 units Anthem Rx Direct Mail Service: 100% of allowable cost after copayment up to a 90 day supply	<table><thead><tr><th></th><th>Network</th><th>Non-network</th></tr></thead><tbody><tr><td>Subject to Deductible</td><td></td><td></td></tr><tr><td>Co-pays apply after deductible satisfied</td><td></td><td></td></tr><tr><td>Tier 1</td><td>\$10</td><td>40%</td></tr><tr><td>Tier 2</td><td>\$20</td><td>40%</td></tr><tr><td>Tier 3 & 4</td><td>40% (Minimum \$40, Maximum \$100)</td><td>40%</td></tr><tr><td>Tier 1</td><td>\$20</td><td>Not Covered</td></tr><tr><td>Tier 2</td><td>\$40</td><td>Not Covered</td></tr><tr><td>Tier 3 & 4</td><td>40% (Minimum \$80, Maximum \$150)</td><td>Not Covered</td></tr></tbody></table> <p>The network penalty will be waived if there is no network pharmacy within 12 miles of the participant's home.</p> <p>The prescription drug copays do not apply to the medical out-of-pocket.</p>				Network	Non-network	Subject to Deductible			Co-pays apply after deductible satisfied			Tier 1	\$10	40%	Tier 2	\$20	40%	Tier 3 & 4	40% (Minimum \$40, Maximum \$100)	40%	Tier 1	\$20	Not Covered	Tier 2	\$40	Not Covered	Tier 3 & 4	40% (Minimum \$80, Maximum \$150)	Not Covered
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See Benefit Booklet for exclusions.

Notes:

- Dependent age: to end of the calendar year after the child's 19th birthday; or to the end of the calendar year after the child's 23rd birthday if the Dependent qualifies as a Full Time Student.
- No deductible carry over credit
- All co-insurance paid for services subject to the 40% OON coverage, is subject to the deductible.** *This benefit description is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.*